**U.S. Department of Labor**

Office of Administrative Law Judges
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**Issue Date: 21 August 2007**

CASE NO. 2005-BLA-6319

In the Matter of:

R.S.,

Claimant

v.

KC ROGERS COAL CO. INC.,

Employer,

and

EMPLOYERS INSURANCE OF WAUSAU,

Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,

Party-in-Interest.

APPEARANCES:

Stephen A. Sanders, Esq.
Prestonsburg, Kentucky
For the Claimant

Carl Brashear, Esq.
Lexington, Kentucky
For the Employer

Before: LARRY S. MERCK
Administrative Law Judge

## DECISION AND ORDER DENYING REQUEST FOR MODIFICATION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq.* The Act and implementing regulations, 20 C.F.R. Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners, who are totally disabled due to pneumoconiosis, and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 C.F.R. § 718.201 (2005). In this case, Claimant alleges that he is totally disabled by pneumoconiosis.

All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 C.F.R. Part 18 (2005). At the formal hearing, Director's Exhibits ("DX") 1-54, Employer's Exhibits ("EX") 1-3, and Claimant's Exhibits ("CX") 1-7 were admitted into evidence. Transcript ("Tr.") at 6-10. Claimant and Employer submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence and the arguments of the parties.

PROCEDURAL HISTORY:

Claimant filed his initial claim on April 8, 2004 (DX 2). On January 11, 2005, the claim was denied by a claims examiner in the office of the District Director on the grounds Claimant established the existence of pneumoconiosis arising from coal mine employment but that he was not totally disabled by the disease (DX 33). On February 15, 2005, Claimant submitted additional medical evidence for consideration by the District Director (DX 35). On February 17, 2005, a claims examiner forwarded the new medical evidence to all parties and Claimant's correspondence was processed as a request for modification of the January 11, 2005, denial under § 725.310 (DX 36). On June 22, 2005, a claims examiner in the office of the District Director denied Claimant's request for modification (DX 42). Claimant appealed and the claim was forwarded to the Office of

Administrative Law Judges for a formal hearing on September 21, 2005. (DX 44, 52).

APPLICABLE STANDARDS:

Section 22 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 922, as incorporated into the Black Lung Benefits Act by 30 U.S.C. § 932(a) and as implemented by 20 C.F.R. § 725.310, provides that upon a miner's own initiative, or upon the request of any party on the grounds of a change in conditions or because of a mistake in a determination of fact, the fact-finder may, at any time prior to one year after the date of the last payment of benefits or any time before one year after the denial of a claim, reconsider the terms of an award or a denial of benefits. § 725.310(a). Because Claimant's request for modification was made within one year after the final denial of his claim, Claimant's motion is timely and will be considered under the relevant regulatory provisions found at § 725.310.

In deciding whether a mistake in fact has occurred, the United States Supreme Court stated that the Administrative Law Judge has "broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keeffe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971). Furthermore, the Sixth Circuit Court of Appeals, under whose appellate jurisdiction this case arises, has held that a modification petition need not specify any factual errors or change in conditions, and indeed, Claimant may merely allege that the ultimate fact - total disability due to pneumoconiosis - was wrongly decided and request that the record be reviewed on that basis. The "adjudicator has the authority, if not the duty, to reconsider all the evidence for any mistake of fact or change in conditions." *Consolidation Coal Co. v. Director, OWCP*, 27 F.3d 226 (6th Cir. 1994).

In determining whether a change in conditions has occurred requiring modification of the prior denial, the Board has similarly stated that

> the administrative law judge is obligated to perform an independent assessment of the newly submitted evidence, considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish

> at least one element of entitlement which defeated entitlement in the prior decision.

*Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. l-6 (l994). Furthermore,

> if the newly submitted evidence is sufficient to establish modification . . ., the administrative law judge must consider all of the evidence of record to determine whether the Claimant has established entitlement to benefits on the merits of the claim.

*Kovac v. BCNR Mining Corp.,* 14 B.L.R. 1-156 (1990). Modified on recon., 16 B.L.R. 1-71 (1992).

The Miner's claim was denied because the evidence was found insufficient to establish total disability. Thus, newly submitted evidence will now be reviewed in conjunction with the prior evidence to determine whether Claimant is now totally disabled. The entire record will be reviewed to determine whether a mistake in a determination of fact occurred in the prior denial.

## ISSUES[1]

1. Whether Claimant has pneumoconiosis as defined by the Act and the regulations.

2. Whether Claimant's pneumoconiosis arose out of coal mine employment.

3. Whether Claimant is totally disabled.

4. Whether Claimant's disability is due to pneumoconiosis.

5. Whether the evidence establishes that a change in conditions and/or that a mistake was made in the determination of any fact in the prior denial per 20 C.F.R. § 725.310.

(DX 52; Tr. 10-11, 30-31).

[1] At the formal hearing, Employer withdrew the issues of timeliness, responsible operator, miner, dependency, and insurance. Employer maintains issues for appeal purposes. (Tr. 10-11). The parties stipulated to fifteen years of coal mine employment (Tr. 11).

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

Claimant was born on December 7, 1946 (DX 2; Tr. 13). Claimant has two dependents for the purpose of benefit augmentation, his wife, C.S. and daughter, A. S., who is a full time college student. (DX 2, 8, 9; Tr. 13-14). 20 C.F.R. § 725.209(2001).

Claimant's last coal mine employment was with KC Rogers Coal Company Incorporated. (DX 3; Tr. 15). His coal mining jobs included about every job in an underground mine to include operating different types of drills, working on the belt line, operating a bolt machine, cutting machine; and he was a mine foreman. (Tr. 16-22; DX 3). He was exposed to significant amounts of coal dust. (Tr. 16, 21-22). In 1993, he stopped coal mine employment as a result of back and neck injuries. (Tr. 14-15, 29).

Claimant's treating physician is Dr. Stumbo. Also, Dr. Anderson is a specialist who treats his lung problems. (Tr. 23). Claimant testified that his breathing problems began in 1988 (Tr. 21). He is currently taking Advair, Combivent and Albuterol to treat his breathing difficulties (Tr. 23). He suffers from shortness of breath, especially if he exerts himself, by walking or climbing stairs, and his breathing problems make it difficult for him to sleep. (Tr. 25).

Claimant smoked from about the age of thirteen until he was twenty-one at a rate of about one-half pack of cigarettes per day (Tr. 24). Claimant has not smoked for about thirty-nine years. *Id.* Dr. Anderson recorded that Claimant smoked for about seven years, quitting in 1968. (CX 1). Dr. Baker noted that Claimant started smoking at the age of fourteen and quit at the age of twenty-one at a rate of one-half pack of cigarettes a day. (DX 12). I find that Claimant has a smoking history of approximately three and one-half pack years, quitting at the age of twenty-one.

Length of Coal Mine Employment:

The duration of a coal miner's employment is relevant to the applicability of various statutory and regulatory presumptions. At the hearing, the parties stipulated to fifteen years of coal mine employment. (TR 11). Based upon my full review of the record, I accept the stipulation and credit

Claimant with fifteen years of coal mine employment, as that term is defined by the Act and Regulations. (DX 2-6). He last worked in the Nation's coal mines in 1993.[2] (TR 14-15; DX 2).

Medical Evidence:

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the newly submitted x-ray findings available in connection with the current claim.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B, or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, and 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b) (2005). Any such readings are, therefore, included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), and/or the registry of physicians' specialties maintained by the

[2] Claimant's last coal mine employment was in the Commonwealth of Kentucky (DX 6). Therefore, this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

American Board of Medical Specialties.[3] If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A=NIOSH certified A reader; B=NIOSH certified B reader; BCR=Board-certified in Radiology. Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

| **Date of X-ray** | **Read as Positive for Pneumoconiosis** | **Read as Negative for Pneumoconiosis** | **Silent as to the Presence of Pneumoconiosis** |
|---|---|---|---|
| 06/07/04 | Cappiello, B/BCR<br>(CX 3) 1/0 p/p<br><br>Baker, B<br>(DX 12) 1/0 p/t | Poulos, B/BCR<br>(EX 1) Negative<br>Poor quality/ underexposed | Barrett, B/BCR<br>(DX 13) Quality only,<br>Good |
| 11/19/03 | Anderson, B<br>(DX 11) 1/1 p/s | Poulos, B/BCR<br>(EX 1) Negative<br>Poor quality/ under exposed | |
| 02/05/02 | Segarra, B/BCR<br>(DX 11) 1/1 t/s | Poulos, B/BCR<br>(EX 1) Negative | |

[3] NIOSH is the Federal Government Agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, August 29, 2005, found at http://www.oalj.dol.gov/ PUBLIC/BLACK LUNG/REFERENCES/REFERENCE WORKS/BREAD3 08 05.HTM. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the website of the American Board of Medical Specialties found at http://www.abms.org.

| Date of X-ray | Read as Positive for Pneumoconiosis | Read as Negative for Pneumoconiosis | Silent as to the Presence of Pneumoconiosis |
|---|---|---|---|
| 7/11/05 | Anderson, B (CX-2,5) Consistent with pneumoconiosis | | |

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. Tests most often relied upon to establish disability in black lung claims measure forced vital capacity (FVC), forced expiratory volume in one-second ($FEV_1$), and maximum voluntary ventilation (MVV). The following chart summarizes the results of pulmonary function studies available with the current claim. Pulmonary function studies submitted by the parties in connection with the current claim are in accordance with the limitations contained in 20 C.F.R. § 725.414 (2005). "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the $FEV_1$ must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the $FEV_1$/FVC ratio must be 55% or less. 20 C.F.R. § 718.204(b)(2)(i) (2005).

| **Ex. No. Date Physician** | **Age Height[4]** | **$FEV_1$ Pre-/ Post** | **FVC Pre-/ Post** | **$FEV_1$/ FVC Pre-/ Post** | **MVV Pre-/ Post** | **Qualify?** | **Physician Impression** |
|---|---|---|---|---|---|---|---|
| DX 11<br>11/19/03<br>Anderson | 56/75″ | 1.88/<br>2.15 | 2.66/<br>2.54 | 71%/<br>84% | ----<br>---- | YES<br>yes | Moderate obstructive airway disease. |
| DX 16<br>11/04/04<br>Skider | 57/75″ | 2.65<br>2.45 | 3.36<br>3.15 | 78.94/<br>77.61 | 42.44/<br>----- | NO<br>yes | Mild restrictive ventilatory defect. |
| CX 2<br>07/11/05<br>Anderson | 58/75″ | 1.72/<br>1.82 | 2.53/<br>2.19 | 68%/<br>83% | ----- | Yes<br>yes | Impossible to adequately evaluate the flow volume loop due to excessive variability such as might be produced by coughing. |
| CX 5<br>07/10/06<br>Anderson | 59/75 | 2.00 | 2.60 | 77% | ----- | Yes | Mild restrictive airway disease suggested |

[4] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). I find Claimant's height to be 75."

| Ex. No. Date Physician | Age Height[4] | $FEV_1$ Pre-/ Post | FVC Pre-/ Post | $FEV_1$/ FVC Pre-/ Post | MVV Pre-/ Post | Qualify? | Physician Impression |
|---|---|---|---|---|---|---|---|
| DX 12 06/07/04 Baker | 57/72.75″ | 2.91 | 3.77 | 77% | ----- | No | Incomplete flow volume loops suggestive of suboptimal effort |

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen ($pO_2$) and the percentage of carbon dioxide ($pCO_2$) in the blood. A lower level of oxygen ($O_2$) compared to carbon dioxide ($CO_2$) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the newly submitted arterial blood gas studies available in this case. Arterial blood gas studies submitted by the parties in connection with the current claim are in accordance with the limitations contained in 20 C.F.R. § 725.414 (2005). A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b) (2005).

| Exhibit Number | Date | Physician | $pCO_2$ at rest/ exercise | $pO_2$ at rest/ exercise | Qualify? | Physician Impression |
|---|---|---|---|---|---|---|
| DX 12 | 06/07/04 | Baker | 39 | 82 | No | |

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A

determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 C.F.R. §§ 718.202(a)(4) (2005). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 C.F.R. § 718.202(a)(4)(2005). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be, nevertheless, found if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, *i.e.*, performing his usual coal mine work or comparable and gainful work. 20 C.F.R. § 718.204(b)(2)(iv) (2005). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 C.F.R. § 718.204(c)(2) (2005). The record contains the following medical opinions.

On December 23, 2004, Dr. James R. Castle, a Board-certified Internist, Pulmonologist, and B reader, prepared a consultative medical report (DX 18). He opined that the November 4, 2004, pulmonary function test was invalid due to only one flow volume loop for each of the pre-bronchodilator and post-bronchodilator studies. He opined that the medical records reviewed were insufficient "to make a diagnosis of pneumoconiosis or any respiratory impairment or disability based upon this inadequate data set and invalid pulmonary function study." *Id.*

Dr. Castle submitted a supplemental report dated April 1, 2005, where he reviewed and commented on newly submitted medical evidence (EX 2). He continued to opine that there was "an inadequate data base to determine whether or not [the Claimant] has coal workers' pneumoconiosis and whether or not he is disabled from any pulmonary process including coal workers' pneumoconiosis." He opined that Dr. Stumbo's letter was

unsupported by objective evidence, and that his conclusions were based on inadequate or invalid data. *Id.*

Dr. Kenneth C. Anderson, a Board-certified Internist, Pulmonologist and B reader, examined Claimant on November 19, 2003, at which time he noted symptoms (cough, mucus, dyspnea, wheeze), employment history (15 years coal mine employment), individual and family histories (high blood pressure, hernia, arthritis, prostate problems), and smoking history (one half pack of cigarettes per day for seven years, quitting 1968). He also performed a physical examination (crackles in lungs), chest x-ray (1/1), and pulmonary function study (moderate obstruction, significant improvement post-bronchodilator) (CX 1). Dr. Anderson diagnosed mixed dust (coal dust and asbestos) pneumoconiosis based on a positive x-ray, crackles on examination, and a history of coal dust exposure; moderate obstruction based on pulmonary function testing; and sleep apnea. Dr. Anderson did not offer an opinion on total disability. *Id.*

Dr. Anderson submitted a July 10, 2006, supplementary report (CX 2). He noted that he had treated Claimant on two more occasions, and that based on his treatment of Claimant, it was his opinion that Claimant suffers from a 50% impairment of the whole person, based on his $FEV_1$ and FVC readings. He listed the impairment etiology as mixed dust related and opined that cigarette smoking history was light and did not significantly contribute to impairment. He opined that Claimant should not have further exposure to coal mining work. *Id.*

Dr. Glen Baker, a Board-certified Internist, Pulmonologist and B reader, examined Claimant on June 7, 2004, at which time he noted symptoms (sputum, wheezing, dyspnea, cough, hemoptysis, chest pain, orthopnea, ankle edema), employment history (15 years coal mine employment), individual and family histories (diabetes, wheezing, back injury, reflux disease, cancer), and smoking history (7 years, ½ ppd, quit age 21). He also performed a physical examination (normal), chest x-ray (1/0), pulmonary function study (mild restriction), arterial blood gas study (normal) and an EKG (normal)(DX 12). Dr. Baker diagnosed coal workers' pneumoconiosis based on a history of coal dust exposure and a positive x-ray; mild restriction due to coal dust exposure; bronchitis, due to coal dust exposure and prior smoking, based on history; and chest pain, by history. He opined that the Claimant suffers from a mild impairment. *Id.*

Dr. Baker submitted a supplemental report dated August 28, 2004 (DX 14). He opined that Claimant's mild restrictive defect "could be due to his weight or possibly due to his Coal Workers' Pneumoconiosis." The defect would correspond to a 15-25% impairment of the whole person, according to the Guide to the Evaluation of Permanent Impairment, Fifth Edition. *Id.*

Dr. Anthony Stumbo, Claimant's treating physician, submitted a November 30, 2004, report (DX 16). He noted "multiple years" of treatment and stated that "evaluations by other MDs has led to a diagnosis of Coal Workers' Pneumoconiosis. He definitely has a disabling breathing problem related to this." *Id.*

Dr. Stumbo submitted a February 8, 2005, letter on behalf of Claimant (DX 35). He opined that "multiple sets of objective data including chest x-ray and pulmonary function testing has adequately illustrated and confirmed this diagnosis [of pneumoconiosis]. My feeling is that [the Claimant] does have significant lung disease and should be considered disabled from that stand point." *Id.*

Dr. Stumbo submitted a May 3, 2005, letter listing the physicians who made the original diagnosis of pneumoconiosis (DX 19). He stated that he concurred with their diagnoses. *Id.*

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal,' pneumoconiosis.
>
> > (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This

> definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (2005).

Twenty C.F.R. § 718.202(a) (2005) provides that a finding of the existence of pneumoconiosis may be based on: (1) chest x-ray; (2) biopsy or autopsy; (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982), or 718.306 (applicable only to deceased miners); or, (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that Claimant has had a lung biopsy and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. As this claim is governed by the law of the Sixth Circuit, Claimant may establish the

existence of pneumoconiosis under any one of the alternate methods set forth at § 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp.*, 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148 to 1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

The District Director found the existence of pneumoconiosis established through the positive x-ray interpretations of Drs. Baker (DX 12), Anderson (DX 11), and Segarra (DX 11). (DX 33). Dr. Barrett reviewed Dr. Baker's June 7, 2004, x-ray for quality purposes only and rated the quality of that film as good (DX 13).

Newly submitted x-ray evidence must be considered in conjunction with the previously submitted evidence. The June 7, 2004, x-ray was read as positive by Dr. Cappiello, a Board-certified Radiologist and B reader. He rated the film quality as "1". (CX 3). Dr. Baker, a B reader interpreted the film as positive for pneumoconiosis with a film quality of "1". (DX 12). Dr. Barrett, a Board-certified Radiologist and a B-reader, re-read the x-ray for quality purposes only and rated the film quality as a "1". Dr. Poulos, a Board-certified radiologist and a B-reader interpreted the x-ray as negative for pneumoconiosis and rated the film quality as "3". The Benefits Review Board ("Board") held that if a physician marks a film quality of "3," "U/R," or, in some cases, a "-," then the x-ray study may be accorded little or no probative value as it is of poor quality. *Gober v. Reading Anthracite Co.*, 12 B.L.R. 1-67 (1988).

Under Part 718, where the x-ray evidence is in conflict, consideration shall be given to the readers' radiological qualifications. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985). Thus, it is within the discretion of the administrative law judge to assign weight to x-ray interpretations based on the readers' qualifications. *Goss v. Eastern Associated Coal Co.*, 7 B.L.R. 1-400 (1984); *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985) (granting great weight to a B-reader); *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n. 5 (1985) (granting even greater weight to a Board-certified radiologist). I give greater weight to the two positive interpretations in conjunction with the two Board-certified radiologists and B-readers who rated the film quality as "1" and find that the June 7, 2004, x-ray evidence is positive for pneumoconiosis.

The November 19, 2003, x-ray was read as positive by Dr. Anderson, a B reader, and as negative by Dr. Poulos, a dually certified physician. I give greater weight to the more qualified reading of Dr. Poulos and find that the November 19, 2003, x-ray evidence is negative for pneumoconiosis.

The February 5, 2002, x-ray was read as positive by Dr. Segarra and as negative by Dr. Poulos, both dually certified physicians. With conflicting interpretations and identical credentials, I find that this x-ray is inconclusive towards the existence of pneumoconiosis.

Taken as a whole, there is one positive film, one negative film and one film in equipoise.[5] All readings are by either B readers or dually qualified physicians. I give greatest weight to the most recent June 7, 2004, x-ray film as it shows the Claimant's most recent health condition. Accordingly, I find that Claimant has established the existence of pneumoconiosis pursuant to § 718.202(a)(1) by a preponderance of the evidence.

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[5] As part of Claimant's treatment records, Claimant submitted a chest x-ray interpretation from Dr. Anderson, dated July 11, 2006, which states: "The patient does appear to have findings consistent with pneumoconiosis. He appears to have small rounded opacities as well as regular opacities. (CX 2, 7). § 725.414(a)(4). This x-ray interpretation does not conform to the standards set forth in the Regulations and is granted little probative weight. *Id.* See § 718.102.

I must next consider the medical opinions. Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the Judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (*en banc*).

The District Director found that the existence of pneumoconiosis was established through the medical opinion evidence and physical examinations of Dr. Baker and Dr. Stumbo, the Claimant's treating physician. (DX 33). Newly submitted medical opinion evidence must be considered in conjunction with the previously submitted evidence.

Dr. Castle opined that the records he reviewed were insufficient "to make a diagnosis of pneumoconiosis or any respiratory impairment or disability based upon this inadequate data set and invalid pulmonary function study." Dr. Castle did not offer an opinion on the existence of pneumoconiosis. A physician's report that is silent as to a particular issue is not probative of that issue. *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

Dr. Anderson, a Board-certified Internist, Pulmonologist and B reader, diagnosed pneumoconiosis based on a positive x-ray, history of coal dust exposure, pulmonary function testing, and physical examination findings. Dr. Anderson based his opinion on objective testing, and he documented which readings supported his opinion. Noting Dr. Anderson's superior credentials, I give his opinion great weight supporting the existence of pneumoconiosis.

Dr. Baker, a Board-certified Internist, Pulmonologist and B reader, diagnosed pneumoconiosis based on a history of coal dust exposure and a positive x-ray. In *Cornett v. Benham Coal Inc.*,

227 F.3d 569 (6th Cir. 2000), the Sixth Circuit Court of Appeals held that such bases alone do not constitute "sound" medical judgment under Section 718.202(a)(4). *Id.* at 576. The Board also holds permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993)(*citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113(1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985)). In *Taylor*, the Board explained that the fact that a miner worked for a certain period of time in the coal mines "does not tend to establish that he does [or does] not have any respiratory disease arising out of coal mine employment." *Taylor*, 8 B.L.R. at 1-407. When a doctor relies solely on a chest x-ray and a coal dust exposure history, his failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray... and not a reasoned medical opinion." *Id.* As Dr. Baker fails to state any reason for his diagnosis of pneumoconiosis beyond the x-ray and exposure history, I find this diagnosis neither well-reasoned nor well-documented.

Dr. Baker also diagnosed bronchitis due to a combination of coal dust exposure and prior smoking. Such a diagnosis, if reasoned, would meet the definition of legal pneumoconiosis. Dr. Baker based his bronchitis diagnosis on past history. He does not document the length of the history relied on. The history given was self-reported by Claimant. As such, it represents subjective evidence and not objective evidence. He fails to explain how a normal physical examination of the chest is consistent with his diagnosis of bronchitis. Finally, he fails to explain how coal dust exposure and/or cigarette smoking causes the diagnosed bronchitis. A "reasoned" opinion is one in which the Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, supra. There is no underlying objective documentation or data to support this diagnosis, and I give it less weight towards a finding of pneumoconiosis.

Dr. Stumbo was Claimant's treating physician. "[T]he opinions of treating physicians are not necessarily entitled to greater weight than those of non-treating physicians in black lung litigation." *Eastover Mining Co. v. Williams*, 338 F.3d 501 (6th Cir. 2003). "[I]n black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade." *Id.* at 510; 20 C.F.R. § 718.104(d). "A highly qualified treating physician who has lengthy experience

with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinion appropriately discounted." *Id*. In addition, appropriate weight should be given as to whether the treating physician's report is well-reasoned and well-documented. *See Peabody Coal Co. v. Groves*, 277 F.3d 829 (6th Cir. 2002); *McClendon v. Drummond Coal Co.*, 12 B.L.R. 2-108 (11th Cir. 1988). Dr. Stumbo presents no pulmonary credentials. He stated that "evaluations by other MDs has led to a diagnosis of Coal Workers' Pneumoconiosis" and that "multiple sets of objective data including chest x-ray and pulmonary function testing has adequately illustrated and confirmed this diagnosis [of pneumoconiosis]." It is proper to accord greater weight to an opinion which is better supported by the objective medical data of record, *i.e.*, x-ray, blood gas, and ventilatory studies. *Midland Coal Co. v. Director, OWCP [Shores]*, 358 F.3d 486 (7th Cir. 2004); *Minnich v. Pagnotti Enterprises, Inc.* 9 B.L.R. 1-89, 1-90 n. 1 (1986); *Wetzel v. Director, OWCP*, 8 B.L.R. 1-139 (1985). Dr. Stumbo failed to list which reports he relied on and he failed to document how those particular reports supported his diagnosis of pneumoconiosis. I find Dr. Stumbo's opinion to be unsupported and not well-documented, and I give it less weight.

Taken as a whole, I give the greatest weight to the well-reasoned opinion of Dr. Anderson, a Board-certified Internist, Pulmonologist and B reader, and find that the existence of pneumoconiosis is established through medical opinion evidence. The other opinions of record either offered no opinion on the issue of pneumoconiosis or were not well-reasoned or supported by objective evidence.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment:

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for 10 or more years. 30 U.S.C. § 921(c)(1); 20 C.F.R. § 718.203(b) (2005). Claimant was employed as a miner for 15 years and, therefore, is entitled to the presumption. Employer has not offered evidence sufficient to rebut the presumption. I conclude that Claimant's pneumoconiosis was caused by his coal mine employment.

Total Disability:

Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his or her usual coal mine work or engage in comparable gainful work in the immediate area of the miner's residence. § 718.204(b)(1)(i) and (ii). Claimant must establish by a preponderance of the evidence that his pneumoconiosis was at least a contributing cause of his total disability. *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994); *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65, 1-66 (1986); *Gee v. Moore & Sons*, 9 B.L.R. 1-4, 1-6 (1986) (*en banc*). Total disability can be established pursuant to one of the four standards in § 718.204(b)(2) or through the irrebuttable presumption of § 718.304, which is incorporated into § 718.204(b)(1). The presumption is not invoked here because there is no x-ray evidence of large opacities and no biopsy or equivalent evidence.

Where the presumption does not apply, a miner shall be considered totally disabled if he meets the criteria set forth in § 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under § 718.204(c), the precursor to § 718.204(b)(2), all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231, 1-232 (1987).

The District Director found that total disability was not established. (DX 33). He relied on nonqualifying arterial blood gas evidence, the most recent nonqualifying pulmonary function test by Dr. Baker, and the lack of a well-reasoned medical opinion stating that Claimant was totally disabled. Newly submitted total disability evidence must be considered in conjunction with the previously submitted evidence.

Section 718.204(b)(2)(i) permits a finding of total disability when there are pulmonary function studies with $FEV_1$ values equal to or less than those listed in the tables and either:

1. FVC values equal to or below listed table values; or,
2. MVV values equal to or below listed table values; or,
3. A percentage of 55 or less when the $FEV_1$ test results are divided by the FVC test results.

The record contains five pulmonary function studies. The fact-finder must determine the reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 B.L.R. 1-154 (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steel Corp.,* 9 B.L.R. 1-131 (1986). Because tracings are used to determine the reliability of a ventilatory study, a study which does not contain three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

As part of Claimant's hospital records, he submitted a pulmonary function study, dated July 10, 2006. (CX 5, 7). Dr. Anderson stated that the pulmonary function study was suggestive of a moderate restrictive defect. *Id.* Because tracings are used to determine the reliability of a ventilatory study, a study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984). Because the three tracings are not included as part of this study, it receives little weight.

Dr. Anderson opined that his July 11, 2005, test was invalid to interpret due to excessive variability in the flow loop volume such as might be produced with coughing. Given Dr. Anderson's own invalidation of his study, I give this study little weight.

Dr. Baker opined that his June 7, 2004, study was suggestive of suboptimal effort. Dr. Castle opined that this test was invalid due to a lack of three tracings. It is important to note, however, that in *Crapp v. U.S. Steel Corp*., 6 B.L.R. 1-476 (1983), the Board held that a non-conforming pulmonary function test may be entitled to probative value where the results exceed the table values, *i.e.*, the test is non-qualifying. As the Board noted, "[d]espite any deficiency in cooperation and comprehension, the demonstrated ventilatory capacity was still above the table values. Had the claimant

understood or cooperated more fully, the test results could only have been higher." Despite potential quality problems and suboptimal effort, Dr. Baker's study produced nonqualifying readings. I give weight to this test and find that it supports no total disability.

Dr. Skider in his written evaluation of the pulmonary function study, dated November 11, 2004, opined that Claimant suffers from mild restrictive lung disease which was most likely secondary to increased body mass index. (DX 16).

Dr. Anderson in his written evaluation of the pulmonary function study, dated November 19, 2003, opined that Claimant suffered from restrictive ventilatory defect with significant improvement after administering bronchodilators. (DX 11).

More weight may be given to the results of a recent ventilatory study over the results of an earlier study. *Coleman v. Ramey Coal Co*., 18 B.L.R. 1-9 (1993). Taken as a whole, I find that the pulmonary function studies that received full probative weight, as discussed, are most indicative of Claimant's disability evaluation. Accordingly, I find that Claimant has not established total disability by a preponderance of the evidence pursuant to § 718.204(b)(2)(i).

Total disability may be found under § 718.204(b)(2)(ii) if there are arterial blood gas studies with results equal to or less than those contained in the tables. The record contains one newly submitted arterial blood gas study, which is nonqualifying. I find that total disability is not established under § 718.204(b)(2)(ii). Arterial blood gas testing shows no change in conditions or that a mistake in determination of fact was made on arterial blood gas testing.

There is no evidence presented, nor do the parties contend that Claimant suffers from cor pulmonale or complicated coal workers' pneumoconiosis.

Under § 718.204(b)(2)(iv) total disability may be found if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine work or comparable and gainful work. To be well-reasoned on the issue of total disability, a physician must compare the exertional requirements of the claimant's usual coal mine employment with an assessment of the claimant's current

respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000); *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993); *Scott v. Mason Coal Co.*, 14 B.L.R. 1-37 (1990)(en banc on recon.).

Dr. Castle stated that the data was insufficient to make a diagnosis as to respiratory impairment, and his silent opinion is due no weight on this issue. *Compton*, supra.

Dr. Anderson opined that Claimant suffers from a 50% impairment of the whole person, based on his $FEV_1$ and FVC readings. He listed the impairment etiology as mixed dust related and opined that cigarette smoking history was light and did not significantly contribute to impairment. He opined that Claimant should not have further exposure to coal mining work. An opinion of the inadvisability of returning to coal mine employment because of a pulmonary condition is not the equivalent of a finding of total disability. *Zimmerman v. Director, OWCP*, 871 F.2d 564, 567 (6th Cir. 1989); *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988); *Bentley v. Director, OWCP*, 7 B.L.R. 1-612 (1984); *Brusetto v. Kaiser Steel Corp.*, 7 B.L.R. 1-422 (1984). Likewise, an opinion advising a claimant to work in a dust-free environment does not constitute a finding of total disability. *White v. New White Coal Co.,* 23 B.L.R. 1-1 (2004). Dr. Anderson also failed to compare the exertional requirements of Claimant's previous coal mine employment against the 50% impairment diagnosed. I find Dr. Anderson's opinion to not be well-reasoned on the issue of total disability, and I give his opinion on this issue less weight.

Dr. Baker opined that Claimant's mild restrictive defect "could be due to his weight or possibly due to his Coal Workers' Pneumoconiosis." (Emphasis added) A physician's opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner "probably" had black lung disease); *see also Justice v. Island Creek Coal Co.,* 11 B.L.R. 1-91 (1988); *Parsons v. Black Diamond Coal Co.,* 7 B.L.R. 1-236 (1984). He also opined that the defect would correspond to a 15-25% impairment of the whole person, according to the Guide to the Evaluation of Permanent Impairment, Fifth Edition. Dr. Baker does not measure Claimant's diagnosed impairment against the exertional requirements of his previous coal mine employment. I find Dr. Baker's opinion on this issue to be equivocal and not well-reasoned, and I give his total disability analysis less weight.

Dr. Stumbo stated that "evaluations by other MDs has led to a diagnosis of Coal Workers' Pneumoconiosis. He definitely has a disabling breathing problem related to this." "My feeling is that [the Claimant] does have significant lung disease and should be considered disabled from that stand point." Dr. Stumbo does not measure the Claimant's diagnosed impairment against the exertional requirements of his previous coal mine employment. He offers no objective testing to support his claim of total disability. An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984); *Phillips v. Director, OWCP*, 768 F.2d 982 (8th Cir. 1985); *Smith v. Eastern Coal Co*, 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983)(a report is properly discredited where the physician does not explain how underlying documentation supports his diagnosis). I find Dr. Stumbo's opinion to be unsupported and not well-reasoned, and I give it little weight.

Because no physician of record exercising reasoned medical judgment finds that Claimant is totally disabled, I find that Claimant has not established total disability by a preponderance of the evidence pursuant to § 718.204(b)(2)(iv). In sum, I find that Claimant has not established by a preponderance of the evidence total disability pursuant to § 718.204(b)(2)(i-iv) *See Kathleen G. Clonch v. Southern Ohio Coal Co.*, (6th Cir. 2006)(unpub.).

Total Disability Due to Pneumoconiosis:

The regulations state that a claimant "shall be considered totally disabled due to pneumoconiosis if pneumoconiosis ... is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment." § 718.204(c)(1). Pneumoconiosis is considered a "substantially contributing cause" of the claimant's disability if it:

(i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or

(ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

§ 718.204(c)(1).

In interpreting this requirement, the United States Court of Appeals for the Sixth Circuit has stated that pneumoconiosis must be more than a *de minimus* or infinitesimal contribution to the miner's total disability. *Peabody Coal Co. v. Smith*, 127 F.3d 504, 506-507 (6th Cir. 1997). Assuming, *arguendo*, that Claimant had established total disability, Claimant is nonetheless ineligible for benefits because he fails to show total disability due to pneumoconiosis as demonstrated by documented and reasoned medical reports. *See* § 718.204(c)(2). No physician of record provided a reasoned medical opinion Claimant was totally disabled due to pneumoconiosis. *See* § 718.204(c)(2). Therefore, I find that Claimant has failed to establish total disability due to pneumoconiosis.

Entitlement:

As Claimant has failed to establish total disability and total disability due to pneumoconiosis, I find that he is not entitled to benefits under the Act. He has not proven a material change in conditions. As such, his claim must be denied.

## ENTITLEMENT TO BENEFITS

As Claimant has failed to establish total disability and total disability due to pneumoconiosis, I find that he is not entitled to benefits under the Act.

## ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for services rendered to him in pursuit of this claim.

## ORDER

The request for modification of the claim for benefits filed by Claimant on April 8, 2004, is hereby DENIED.

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LARRY S. MERCK
Administrative Law Judge

**NOTICE OF APPEAL RIGHTS**: If you are dissatisfied with the Administrative Law Judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P. O. Box 37601, Washington, DC, 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC, 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).